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F 000	INITIAL COMMENTS Complaint investigation #35334 and #35184 was conducted on 3/17/15 through 3/31/15. No deficiencies were cited related to complaint #35334. Deficiencies were cited related to complaint #35184.	F 000		
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop an individualized comprehensive care plan that provided specific interventions to prevent the development of pressure ulcers and to treat existing pressure	F 279	**F 279. Develop Comprehensive Care Plans** 1. Resident identified in alleged deficient practice no longer resides in facility. 2. Residents residing in facility with pressure ulcers have the potential to be affected by this alleged deficiency. Audit of Skin and pain care plans performed by DON /unit manager/MDS Nurse on Residents residing currently in facility with skin issues to include interventions to prevent and treat existing wounds and pain management of current wounds. In-servicing with Licensed Nurses related to developing comprehensive care plan for skin concerns and pain by DON/Unit manager/Unit manager. 3. Initial and comprehensive care plans related to pain management and skin issues will be reviewed and discussed with IDT in morning meeting Monday through Friday. DON/ADON/Unit Manager/MDS Coordinator will review to validate care plans are in place, appropriate for Residents reviewed, and updated as needed. 4. Concerns found in morning meeting will be addressed immediately with Licensed Nursing personnel to make immediate corrections as needed. Results of audit will be reported monthly x 3 to the QAPI committee, consisting of Administrator, DON, ADON, Unit Manager, Social Services Director, Medical Director, Dietary Manager, Maintenance Manager, Activities Director, and Medical Director.	05/10/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	NHA	4/24/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 ulcers and failed to provide specific and individualized interventions to meet pain management needs for one (Resident #2) resident of 5 residents reviewed for pressure ulcers. The facility's failure to develop a comprehensive care plan resulted in actual harm to Resident #2. The findings included: Medical record review revealed Resident #2 was admitted on 10/4/11, readmitted on 5/7/12, and discharged on 10/20/14. Continued medical record review revealed diagnoses including Anemia, Hyperlipidemia, Depression, Hypothyroidism, Pneumonia, Urinary Tract Infection, Arthritis and Coronary Artery Disease. Medical record review of the resident's comprehensive care plan for pressure ulcers revealed an update on 8/8/14 to reflect a "Stage II left medial buttock"; update on 9/8/14 to reflect a "Stage II buttock"; update on 10/5/14 to reflect "unstageable right buttock with eschar"; update on 10/18/14 to reflect "right buttock with eschar - slough depth, undermining, foul odor 3.5 x 3.0 x 3.0 cm (centimeter)." Medical record review of the comprehensive care plan revealed interventions included: apply pressure reduction mattress to bed, apply pressure reduction cushion to chair, reposition in chair frequently for comfort and pressure reduction, turn and reposition while in bed frequently, provide incontinence care, measure and stage wound weekly using the pressure ulcer healing assessment form, complete a full body check weekly and document, pressure ulcer treatment as ordered.	F 279		

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F 279	Continued From page 2 Medical record review of the resident's comprehensive care plan revealed no specific pressure ulcer interventions were provided on the care plan to treat existing pressure ulcers. Medical record review of a Head to Toe Skin Check dated 7/28/14 revealed documentation of an abrasion to the left buttock. Review of a facility Incident/Accident Report dated 8/8/14 revealed an injury of an "...open area on her left medial buttock/self inflicted abrasion..." Review of a facility Incident/Accident Report dated 9/8/14 revealed "...wound on left buttock has increased in size - worse in last few days." Review of the Weekly Pressure Ulcer QA&A dated 9/21/14 revealed Resident #2 had a Stage III pressure ulcer (1.4 x1 x 0.4) to the coccyx and a Stage II pressure ulcer (2.4 x 1.6 x 0.2) to the left buttock. Review of the Weekly Pressure Ulcer QA&A dated 9/28/14 revealed Resident #2 had a Stage III pressure ulcer (1.0 x 1.0 x 0.4) to the coccyx and a Stage II pressure ulcer (1.2 x 2.0 x 0.2) to the left buttock. Review of the Weekly Pressure Ulcer QA&A dated 10/6/14 revealed Resident #2 had a Stage III pressure ulcer (1.0 x 1.0 x 0.4) to the coccyx and a Stage II pressure ulcer (2.8 x 2.0 x 0.2) to the left buttock. Medical Record review of the Weekly Pressure Ulcer Record dated 9/26/14 revealed	F 279		

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F 279	Continued From page 3 documentation of a pressure ulcer (2.4 x 1.6 x 0.2) to the right buttock "closest to outside" (no stage documented) and a Stage III pressure ulcer (1.4 x 1.0 x 0.4) to the right buttock "closest to inside". Medical record review of the Weekly Pressure Ulcer Record dated 10/5/14 revealed documentation of a pressure ulcer (1.7 x 1.5 x1) to the "coccyx closest to inside", "coccyx wound bed black in color" and a Stage II pressure ulcer (1.9 x 2.6 x 0.2) to the right buttock. Medical record review revealed Resident #2 was transferred to a local hospital on 10/20/14 due to "...suspected wound infection with foul odor, necrotic tissue, slough and purulent drainage." Review of the hospital medical record revealed the resident was admitted with a "stage III decubitus ulcer in pre-sacral area with tunneling and necrotic tissue...placed on a wound vac..." Interview with the Director of Nursing (DON) on 3/26/15 at 10:15 AM in the DON's office confirmed the Weekly Pressure Ulcer Record description of the resident's wounds and the description of the wounds on the resident's care plan were inconsistent. Medical record review of the resident's comprehensive care plan related to pain dated 4/17/14 and updated on 7/17/14 and 10/7/14 revealed interventions to provide scheduled pain meds, medicate resident for pain prior to treatments and therapy, if indicated, notify physician if interventions are not consistently effective, administer analgesics as ordered and implement pain management flowsheet.	F 279		

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Medical record review of a Medication Administration Record (MAR) dated 7/2014 documented the following orders:

Hydrocodone-Acetamin (Acetaminophen) 5mg (milligram)-325mg tablet (Norco) 1 tablet by mouth every 8 hours scheduled hold for sedation. Scheduled at 6:00 AM, 2:00 PM and 10:00 PM. Ordered on 11/30/12.

Hydrocodone-Acetaminoph 7.5-325mg tablet (Norco) 1 tablet by mouth twice daily PRN (as needed for pain). Ordered 2/16/14.There was no documentation of the PRN medication on the MAR- a hand written note said "see pain flow
sheet."

Acetaminophen 650mg (2 tabs of 325 = 650mg) (Tylenol) (650mg) by mouth every 6 hours as needed pain (rated 1-5). Ordered 7/25/12. There was no documentation of the PRN medication on the MAR- a hand written note said "see pain flow sheet."

Medical record review of the PRN (as needed) Pain MAR dated 7/2014 documented the resident received a 7.5/325mg tablet of Norco on 7/4 at 11:15 PM for a verbal complaint of pain rated a 9 out of 10. There was no post administration documentation describing how effective the medication was or what the pain was rated after administration.

Review of the MAR dated 8/2014 revealed the resident did not receive her scheduled pain medication on 8/7/14 at 2:00 PM or 8/21/14 at

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F 279	Continued From page 5 2:00 PM. There was no further documentation explaining why the resident did not receive her scheduled pain medication. There was no 8/2014 PRN Pain MAR provided by the facility. Review of the 9/2014 MAR revealed the resident did not receive her scheduled pain medication on 9/5/14 at 10:00 PM, or 9/28/14 at 6:00 AM. Medical record review of a Nurse's Notes dated 9/1/14 at 12:30 AM revealed "...resident lying in bed with complaint of pain while turning and repositioning. Wound to (L) (left) buttock cleaned and dressing applied..." No PRN pain medication provided. Continued review revealed an untimed, unsigned Nurse's Note dated 9/24/14 documented "...wound to (L) buttock cleaned and optifoam dressing applied. Resident complained of pain and received scheduled pain medication..." No PRN pain medication was documented as given to the resident prior to wound care as ordered by the physician. Medical record review of a Weekly Pressure Ulcer Record dated 9/26/14 revealed "...Pt (patient) c/o (complained of) pain while dressing is being changed....Pt c/o [increased] pain when sitting up..." Medical record review of an Activities Progress Note dated 10/6/14 revealed "...not as alert...frequently yells out in pain when awake..." Medical record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/7/14 revealed the resident had received scheduled pain medication, and PRN (as needed) pain medication within the last 5 days, but had not received a non-medication	F 279		

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F 279	Continued From page 6 intervention for pain. The resident experienced pain or hurting frequently and the pain had made it hard for her to sleep at night, and she was unable to answer if there were limitations in her day to day activities related to pain. The resident was unable to rate the pain on a 1-10 numeric scale. No further documentation regarding pain was noted on the MDS. An interview with the Director of Nursing and Administrator on 3/31/15 at 6:30 PM in the Conference Room confirmed the facility failed to develop a comprehensive care plan with specific interventions to prevent and treat existing pressure ulcers and accurately reflect the resident's pressure sore development, failed to develop a comprehensive care plan that provided specific and individualized interventions for pain management and resulted in actual harm to Resident #2.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280	**F 280. Right to Participate in Planning Care- Revise CP** 1. Resident identified in alleged deficient practice no longer resides in facility. 2. New admissions/readmissions have potential to be affected by this alleged deficiency. Audits were performed on new current Residents admitted within the 30 days prior to 4/26/15 to validate care plan are in place By DON/Unit Manager/MDS Nurse . Updates made as necessary on current Residents to validate needs are reflected on Care Plans. In – servicing given to Licensed Nurses related to developing initial Care Plan on admission/readmission. 3. New admissions/readmissions will be discussed in morning meeting Monday through Friday by IDT. Initial nursing Care Plans will be updated or created as need. New admissions will be reviewed by	

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F 280	Continued From page 7 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview the facility failed to update the care plan to reflect the residents specific wound care needs and interventions, and to revise the care plan after the resident was readmitted to the facility for 3 (Resident #1, Resident #5, Resident #6) residents of 7 residents reviewed. The findings included: Medical record review revealed Resident #1 was admitted to the facility on 2/27/15, discharged to the hospital on 3/1/15, re-admitted on 3/5/15 and discharged back to the hospital on 3/16/15 with diagnoses including Pneumonia, Congestive Heart Failure, Hypertension, and Flaccid Hemiplegia. Medical record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/15 revealed the resident required extensive assistance from 2 people for bed mobility and transfers, assistance from 1 person for dressing, eating, toileting, and personal hygiene, and was totally dependent for bathing. Review of the care plan development policy in the PointClickCare system with a revision date of 10/18/13 revealed "...process of care plan	F 280	DON/ADON/Unit Manager or MDS Nurse to validate that Care Plan is in place. 4. Concerns found in morning meeting will be reported to monthly x 3 to the QAPI committee, consisting of Administrator, DON, ADON, Unit Manager, Social Services Director, Medical Director, Dietary Manager, Maintenance Manager, Activities Director, and Medical Director.	05/10/2015

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development requires the review of the resident's status in a holistic manner...must represent the resident's status, needs...each resident shall have an Initial Plan of Care developed within 24 hours of admission to the facility that addresses identified risk areas and resident's initial individual needs ...is developed based on information received from the referring facility, physician orders...clinical screens and assessments...any additional plan of care entries will be made manually on paper by the [IDT] Interdisciplinary Team..."

Medical record review of the Nursing Initial Plan of Care, effective date 2/27/15 and signed on 3/11/15 revealed,"...Potential/Actual Skin Issues related to: Pressure Ulcer related to Incontinence, pressure ulcer to sacrum with treatment in place..." Interventions include "...provide wound care/preventative skin care per order; Skin checks weekly per facility protocol, document findings; Notify MD of changes in wound or emerging wounds; Turn and reposition frequently to decrease pressure...try/dry and provide pericare q2h (every 2 hours) and prn (as needed) for incontinence..."

Medical record review of a physician's order dated 3/6/15 revealed a verbal order for "...Santyl (wound medication) Ointment 250 Unit/GM (gram) (Collagenase) Apply to Sacral Wound topically every day shift every other day for Sacral wound, Cleanse with WC (wound cleaner), pat dry, cover wound boarder with Sureprep, apply Santyl (wound bed only), cover with Hydrocolloid dressing, and change QOD (every other day) and PRN for soiling ..."

Interview with LPN #1 on 3/31/15 at 1:10 PM in

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F 280	Continued From page 9 the conference room confirmed a newly admitted resident is assigned to a specific nurse, and that nurse is responsible for initiating an interim care plan within the first 24 hours. Continued interview confirmed that when a resident is re-admitted, the complete admission process starts over, including physician orders, assessments, and a new or updated care plan. Interview with the DON on 3/31/15 at 5:20 PM in the conference room confirmed the Nursing Initial Plan of Care dated 2/27/15 did not contain specific wound care interventions for Resident #1 and had not be revised or updated after the 3/5/15 re-admission to the facility. Medical record review of Resident #5 revealed the resident was readmitted to the facility on 2/19/15 with diagnoses including Aftercare for Healing Traumatic Fracture of Hip, Diabetes Mellitus, Congestive Heart Failure, Atrial Fibrillation (abnormal heart rhythm), Muscle Weakness and Difficulty in Walking. Medical record review of Nursing Admission Data Collection dated 2/19/15 revealed "...Skin Assessment: Coccyx, Skin Shearing, 7 x 2 cm; Right Trochanter (hip), Surgical Incision, 30x 1 cm....Left Heel, Pressure, 3 x 2 cm, Unstageable...." Medical record review of Nursing Initial Plan of Care initiated on 12/2/14 and revised on 3/17/15 revealed "....has potential/actual skin issues ...Interventions: Provide wound care/preventive skin care per order (initiated 12/2/14)...Treatment as ordered (date initiated 3/5/15)..."	F 280		

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Medical record review of Physician's Orders dated 2/27/15 revealed "...Left heel... Cleanse with wound cleaner, pat dry, apply SurePrep (skin protectant) to wound borders, apply Santyl (topical ointment aids in wound healing) to wound bed only and cover with dry dressing every other day (QOD) and as needed (PRN)..."

Medical record review of Physician's Orders dated 2/27/15 revealed "...Sacrum... Cleanse with wound cleaner, pat dry, apply SurePrep to wound borders, apply Santyl to wound bed only and cover with dry dressing QOD and PRN..."

Medical record review of Physician's Orders dated 3/3/15 revealed "...Right Hip ... Cleanse with wound cleaner, pat dry, coat staple line with sure prep and cover with long boarder gauze every day(QD) and PRN for soiling..."

Medical record review of Physician s Orders dated 3/3/15 revealed "...Left Heel ...Cleanse with wound cleaner, pat dry, apply sure prep to wound borders, apply Santyl to wound bed only, apply Alginate (an absorbent wound dressing), and cover with dry dressing (not foam) QOD and PRN for soiling..."

Medical record review of Treatment Administration Record (TAR) dated 2/1/15-2/28/15 revealed no documentation of wound care administered to the left heel on 2/28/15.

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Medical record review of TAR dated 2/1/15-2/28/15 revealed no documentation of wound care administered to the left sacrum on 2/28/15.

Medical record review of TAR dated 3/1/15-3/31/15 revealed no documentation of wound care administered to the left heel on 3/10/15 and 3/21/15.

Medical record review of TAR dated 3/1/15-3/31/15 revealed no documentation of wound care administered to the left sacrum until 3/4/15 and then again on 3/11/15.

Medical record review of TAR dated 3/1/15-3/31/15 revealed no documentation of wound care administered to the right hip on 3/7/15, 3/10/15, 3/11/15, 3/13/15 and 3/18/15.

Interview with the DON on 3/31/15 at 6:00 PM in the Conference Room confirmed the care plan for Resident #5 was not revised upon the resident's readmission to the facility on 2/19/15. The DON further confirmed that the resident's care plan was dated 12/2/14 and not revised until 3/17/15.

Medical record review of Resident #6 revealed the resident was admitted to the facility on 3/12/15 with diagnoses including Gout, Recent Right Hip Fracture, Cerebrovascular Accident, Pneumonia and Deep Vein Thrombosis.

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Medical record review of Wound Care Orders dated 3/12/15 revealed "...Right and Left Heel...Sureprep QD and PRN...Right Buttock...Cleanse with WC, pat dry, apply Alginate Cover with Dry Dressing and change QD..."

Medical record review of Nursing Initial Plan of Care dated 3/12/15 revealed "...has potential/actual skin issues...Interventions: "... Skin checks weekly per facility protocol... Turn and reposition frequently to decrease pressure..." No interventions addressing the resident's pressure ulcers and pressure ulcer treatment were present on the interim care plan.

Medical record review of the Care Plan dated 3/27/15 revealed "... admitted with several pressure ulcers...Stage III Right Buttock and unstageable to Bilateral Heels...Administer treatment as ordered and observe for effectiveness..."

Medical record review of TAR dated 3/1/15 to 3/31/15 revealed "...Right Buttock...Cleanse with WC, pat dry, apply Alginate Cover with Dry Dressing and change QD, Order Date 3/12/15..."Continued review of the TAR revealed no documentation that pressure ulcer care was provided on 3/17/15 and 3/19/15.

Interview with the DON on 3/31/15 at 6:00 PM in the Conference Room confirmed the interim care plan dated 3/12/15 for Resident #6 did not address the resident's pressure ulcer treatment

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F 280	Continued From page 13 needs.	F 280		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, weekly pressure ulcer record review, interdisciplinary care conference attendance record review, and interview, the facility failed to obtain a physician's order for wound care treatment for 1 (Resident #3) residents of 7 residents reviewed, and failed to implement, and modify pain management interventions for 1 (Resident #2) resident of 7 residents reviewed for pain management resulting in the resident's inability to maintain and reach her highest practicable well being and causing actual harm to Resident #2. The findings included: Medical record review revealed Resident #2 was admitted to the facility on 10/4/11, was readmitted on 5/7/12 and discharged on 10/20/14 with diagnoses including Anemia, Hyperlipidemia, Depression, Hypothyroidism, Pneumonia, Urinary Tract Infection, Arthritis and Coronary Artery Disease.	F 309	**F 309. Provide Care/Services for Highest Well-Being** 1. Resident #2 identified in alleged deficient practice no longer resides in facility. Resident #3 identified in alleged deficient practice-Wound care treatment orders reviewed by wound care physician. Orders confirmed and treatment continued. 2. Residents residing in facility with skin concerns and pain concerns related to skin issues have the potential to be affected by this alleged deficient practice. Audits performed of current resident with identified skin concerns to validate orders are in place and implemented completed by DON/Unit Manager/MDS nurses. Pain assessments completed on current residents with skin concerns by DON/Unit Manager/charge nurses. 3. In-servicing to Licensed Nurses by DON/ADON/Unit Manager on getting and implementing treatment orders and pain management of residents with skin concerns. In-servicing provided to CNA and other members of IDT on signs and symptoms of pain and who to report them to. Residents with identified wounds will be reviewed weekly by IDT consisting of DON or Unit Manager, SSD, MDS nurse to validate treatment orders in place and pain is addressed. New admission/ readmissions will be reviewed Monday through Friday in morning meeting to validate any identified skin concerns are being treated as needed and that pain is addressed. 4. Concerns found in morning meeting will be reported to monthly x 3 to the QAPI committee, consisting of DON, Administrator, Medical Director, Social Services Director, and Medical Records.	05/10/2015

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F 309	Continued From page 14 Medical record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/14 revealed the resident was totally dependent requiring assistance from 2 people for transferring, dressing, toileting, personal hygiene and required assistance from 1 person for bathing. The resident required extensive assistance from 2 people for bed mobility and assistance from 1 person for eating. The resident was assessed to be frequently incontinent of urine and always incontinent of bowel. The resident was assessed to have been on scheduled pain medication, and had received PRN (as needed) pain medication over the last 5 days and had also received non-medication intervention for pain. The resident answered "yes" she had pain or hurting in the past 5 days but was unable to answer how often. The resident was unable to answer if her day to day activities were limited because of the pain. The location of the pain was documented as generalized joint pain caused by arthritis and neuropathy. The Pain Evaluation revealed rest, positioning and medication administration relieved the pain. The resident was unable to describe the quality of the pain. The manner of expressing pain symptoms documented verbalization, grimacing, groaning, and frowning. The Brief Interview for Mental Status (BIMS) scored the resident a 2 out of 15 signifying the resident was severely cognitively impaired. Medical record review of the comprehensive care plan dated 7/17/14 with a problem of potential Pain related to joint pain, chronic disease process, neuropathic pain and musculoskeletal documented Approaches of Positioning/support;	F 309		

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F 309	Continued From page 15 Administer analgesics as ordered; See physician orders; Implement pain management flowsheet; Observe resident for signs and symptoms of pain, including verbal expressions and nonverbal expressions (facial grimacing bracing, restlessness, rubbing, other) Frequency of monitoring QS (every shift); Notify physician if interventions are not consistently effective; Medicate resident for pain prior to treatments and therapy, if indicated; therapy referral as indicated. The care plan was updated on 10/7/14 with a problem of actual pain related to a skin ulcer/wound. A new intervention of "...scheduled pain meds (medications) was added at this time. Medical record review of a Medication Administration Record (MAR) dated 7/2014 revealed the following orders: Hydrocodone-Acetamin (Acetaminophen) 5mg (milligram)-325mg tablet (Norco) 1 tablet by mouth every 8 hours scheduled hold for sedation. Scheduled at 6:00 AM, 2:00 PM and 10:00 PM. Ordered on 11/30/12 Hydrocodone-Acetaminoph 7.5-325mg tablet (Norco) 1 tablet by mouth twice daily as needed for pain. Ordered 2/16/14. There was no documentation of the PRN medication on the MAR- a hand written note said "see pain flow sheet." Acetaminophen 650mg (2 tabs of 325 = 650mg) (Tylenol) (650mg) by mouth every 6 hours as needed pain (rated 1-5). Ordered 7/25/12.There was no documentation of the PRN medication on the MAR- a hand written note said "see pain flow sheet."	F 309		

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F 309	Continued From page 16 Medical record review of the PRN Pain MAR dated 7/2014 revealed the resident received a 7.5/325mg tablet of Norco on 7/4 at 11:15 PM for a verbal complaint of pain rated a 9 out of 10. There was no post administration documentation describing how effective the medication was or what the pain was rated after administration. The resident received another dose on 7/25 at 3:30 PM after facial grimaces of a "10" were observed. Review of the MAR dated 8/2014 revealed the resident did not receive her scheduled pain medication on 8/7/14 at 2:00 PM or 8/21/14 at 2:00 PM. There was no further documentation explaining why the resident did not receive her scheduled pain medication. There was no 8/2014 PRN Pain MAR provided by the facility. Review of the 9/2014 MAR revealed the resident did not receive her scheduled pain medication on 9/5/14 at 10:00 PM, or 9/28/14 at 6:00 AM. Medical record review of a Nurse's Notes dated 9/1/14 at 12:30 AM revealed "...resident lying in bed with complaint of pain while turning and repositioning. Wound to (L) (left) buttock cleaned and dressing applied..." No PRN pain medication provided. Continued review revealed an untimed, unsigned Nurse's Note dated 9/24/14 documented "...wound to (L) buttock cleaned and optifoam dressing applied. Resident complained of pain..." Medical record review of a Weekly Pressure Ulcer Record dated 9/26/14 revealed "...Pt (patient) c/o (complained of) pain while dressing is being changed...Pt c/o [increased] pain when sitting up..."	F 309		

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F 309	Continued From page 17 Medical record review of an Activities Progress Note dated 10/6/14 revealed "...not as alert..frequently yells out in pain when awake..." Medical record review of the Quarterly MDS with an ARD of 10/7/14 revealed the resident had received scheduled pain medication, and PRN (as needed) pain medication within the last 5 days, but had not received a non-medication intervention for pain. The resident experienced pain or hurting frequently and the pain had made it hard for her to sleep at night, and she was unable to answer if there were limitations in her day to day activities related to pain. The resident was unable to rate the pain on a 1-10 numeric scale. Review of Nursing Progress note dated 10/13/14 at 4:09 PM revealed "...patient yelling while dressing changed..." Review of an Interdisciplinary Care Conference Attendance Record dated 10/16/14 revealed "...called son to inform of...wound decline and episodes of resident yelling out and pain..." Medical record review of a physicians order dated 10/18/14 revealed "...Foley cath (catheter) placement dx (diagnosis): intractable pain..." Medical record review of a Nursing Progress Note dated 10/19/14 at 10:24 PM revealed "...while...performed peri-care...resident noted to be crying..." Medical record review of the 10/2014 MAR revealed the scheduled pain was changed from 5/325mg of Norco every 8 hours to 7.5/325mg 1	F 309		

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F 309	Continued From page 18 po TID (three times daily) on 10/19/14. Medical record review of a physicians order dated 10/20/14 at 9:00 AM revealed "send to...ER (Emergency Room) for evaluation of buttock wound-eschar/slough-foul odor, drainage-undermining-severe pain..." Review of an Interdisciplinary Care Conference Attendance Record dated 10/20/14 revealed "...called son (approx 11:45 AM)...informed him of uncontrollable pain during ADL's (Activities of Daily Living) and dressing changes..." Interview with the Director of Nursing (DON) and the Administrator on 3/31/15 at 6:30 PM in the conference room confirmed Resident #2 had severe pain related to pressures ulcers during repositioning, peri-care, dressing changes, and all ADL's. The facility failed to administer scheduled pain medication 2 times in August and 2 times in September. The facility documented the resident's pain worsened beginning 9/1/14 during peri-care and failed to administer PRN medications. The resident was incontinent of bladder and bowel and had a Stage II pressure ulcer to the buttock documented on 9/8/14 and a Stage III pressure ulcer to the coccyx documented on 9/28/14. An order for a Foley catheter was not written until 10/18/14. The DON confirmed the resident did not receive PRN pain medication before peri-care or pressure ulcer treatment, and providing medication after the care did not address the resident's pain or maintain her highest well being. The facility failed to notify the physician in a timely manner the current pain management plan was not consistently effective, thus resulting in actual harm to Resident #2.	F 309		

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F 309	Continued From page 19 Medical record review of Resident #3 revealed the resident was readmitted to the facility on 3/3/15 with diagnoses including Clostridium Difficle, Chronic Kidney Disease, Generalized pain, Muscle Weakness, Anemia and Diabetes Mellitus. Medical record review of Physician's Orders dated 3/9/15 revealed "...Right outer calf... Cleanse with warm water and soap, pat dry and cover with Optifoam (an absorbant dressing) QOD (every other day) and PRN (as needed)for soiling..." Observation of wound care treatment on 03/19/15 at 1:40 PM in the Resident's room revealed LPN #2 applied Calcium Alginate (an absorbant medication) to the wound. Interview with LPN #2 on 3/19/15 1:46 PM in the resident's room when asked what was placed on the wound, LPN #2 stated "Calcium Alginate. I don't have an order for it, but I will call the doctor and get one." Interview with the DON on 3/19/15 at 3:00 PM in the DON's office, when asked about the absence of orders for Calcium Alginate, the DON confirmed there were no physician's orders for Calcium Aginate and stated "You must have a Physician's Order before applying it."	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314	**F314. Pressure Sores** **1. Residents identified by alleged deficient practice no longer reside in facility.**	

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F 314	Continued From page 20 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, review of facility Incident/Accident reports, Weekly Pressure Ulcer Logs, and interview, the facility failed to prevent, implement, monitor, and provide the necessary treatment for pressure ulcers for 2 (Resident #1, Resident #6) residents of 5 residents reviewed. The failure of the facility to prevent and provide care to treat pressures ulcers resulted in actual harm to 2 (Resident #2, Resident #5) residents of 5 residents reviewed with pressure ulcers. The findings included: Medical record review revealed Resident #2 was admitted to the facility on 10/4/11, was readmitted on 5/7/12 and discharged on 10/20/14 with diagnoses including Anemia, Hyperlipidemia, Depression, Hypothyroidism, Pneumonia, Urinary Tract Infection, Arthritis and Coronary Artery Disease. Review of the Skin Management facility policy with a revision date of 8/12 revealed "...Residents who are at risk or with wounds and/or pressure ulcers and those at risk for skin compromise are identified, assessed and provided appropriate treatment to encourage healing and/or integrity.	F 314	2. Residents residing in the Facility with skin concerns have the potential to be affected by this alleged deficient practice. Skin assessments preformed on current residents residing in facility by DON/ADON/Unit Manager/Charge Nurses. Audits will be done to validate prevention, implementation, monitoring and necessary treatment is in place completed by Don/Unit Manager/Charge Nurse/Treatment Nurse. 3. Skin audits will be scheduled Sunday through Thursday and will be reviewed in Morning meeting Monday through Friday. Any not completed will be done immediately and education provided to Licensed Nurses. Treatment nurse is currently in place to oversee treatment implementation and documentation. Second documentation review, Monday through Friday, conducted by DON/Unit Manager/ADON/MDS nurse. Education to Licensed Nurses related to wound staging, measuring of wounds, performing treatments, and documentation conducted by Micheal Britton Certified Wound Nurse and Dr. Powell Wound Care Physician with post-test competency. In-servicing to Ceritified Nurse Aides on early identification conducted by DON/Unit Manger/ADON/Wound Nurse. Ongoing, new hires will receive the same education/in-servicing. 4. Audits of TARS for residents with wounds will beconducted 3 times a week x 4 weeks, 2 times a week x 4 weeks , then 1 x week x 4 weeks. Concerns will be addressed/corrected upon discovery. Results of audit will be reported to the QAPI committee IDT, consisting of Administrator, DON, ADON, Unit Manager, Social Services Director, Medical Director, Dietary Manager, Maintenance Manager, Activities Director, and Medical Director, monthly x3.	05/10/2015

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F 314	Continued From page 21 Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes..." Further review revealed for bed bound residents "...Avoid positioning a resident directly on a pressure ulcer whenever possible...Use positioning devices. Devices should be used to completely raise the pressure sore area...off of the support surface...Establish an individualized turning schedule based on the resident's clinical condition...Assess for risk of developing additional ulcers..." Medical record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/14 revealed the resident was totally dependent requiring assistance from 2 people for transferring, dressing, toileting, personal hygiene and required assistance from 1 person for bathing. The resident required extensive assistance from 2 people for bed mobility and assistance from 1 person for eating. The resident was assessed to be frequently incontinent of urine and always incontinent of bowel. The Brief Interview for Mental Status (BIMS) scored the resident a 2 out of 15 signifying the resident was severely cognitively impaired. Review of the Braden Scale for Predicting Pressure Sore Risk dated 7/11/14 scored the resident an "11". A total score of 12 or less represents high risk. Risk factors included; Constantly moist; Chairfast; Completely Immobile;and a Friction and Shear problem.	F 314		

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F 314	Continued From page 22 Medical record review of the resident's comprehensive care plan revealed a problem of an actual pressure ulcer on 8/8/14 related to moisture/incontinence, impaired mobility and a friction and shear problem, and described as "...self inflicted scratch/abrasion Stage II (L) (left) medial buttock..." Interventions included; apply pressure reduction mattress to bed; apply pressure reduction cushion to chair; reposition in chair frequently for comfort and pressure reduction; turn and reposition while in bed frequently for comfort and pressure reduction; provide incontinence care after each incontinent episode; measure and stage wound weekly using the pressure ulcer healing assessment form, complete a full body check weekly and document; monitor lab values as ordered; Registered Dietitian referral; pressure ulcer treatment as ordered. The care plan was updated 9/8/14 with a problem of a Stage II buttock ulcer, and again on 10/5/14 with a problem of an unstageable (R) (right) buttock c [with] eschar. The interventions remained the same as were present on 8/8/14. The care plan was updated on 10/18/14 with an actual pressure ulcer to "...(R) buttock c [with]eschar-slough, depth, undermining, foul odor..." the measurements were 3.5 x 3.0 x 3.0 cm (centimeters). The interventions remain the same with the addition of "...NP (Nurse Practitioner) referral to be seen 10/19/14 for [changes] in house..." Medical record review of a physician's order dated 10/29/13 revealed "...weekly skin assessment..."	F 314		

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F 314	Continued From page 23 Review of a facility Incident/Accident Report dated 8/8/14 revealed an injury of an "...open area on her left medial buttock/self inflicted abrasion..." The Summary of Investigation documented "...wound appears to be a scratch...has long hard nails...noted with thick lengthy nails and scratches often..." Past Interventions Attempted documented N/A (not applicable). Recommendations/New Interventions included; "...trim resident's nails; apply skin barrier to buttocks after incontinence; treatments as ordered; observe area for increase in size, odor, pain, drainage, Notify MD/NP..." The measurement of the wound was documented as 1 x 0.2 cm of sheared skin. Medical record review of a TAR dated 8/1-8/31/14 revealed an order dated 8/8/14 to "...apply optifoam (highly absorbent dressing) to left medial buttock q (every) 3 days and PRN (as needed)..." There was no documentation of wound care to the left medial buttock on 8/14, 8/17, 8/20 or 8/29. There was no documentation the weekly skin assessments were completed on 8/4, 8/11, or 8/18. The resident went 11 consecutive days without any wound care or a skin assessment from 8/12-8/23/14. Review of a facility Incident/Accident Report dated 9/8/14 revealed an injury documented as "...wound on left buttock has increased..." The description of the situation documented "...wound from a scratch on left buttock...increased in size...measures...2.2 cm x 3.6 cm no depth..." The Summary of Investigation documented "...noted followup stage 2 next to self inflicted abrasion..." The Past Interventions Attempted	F 314		

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documented "...Optifoam was being applied q 3 days after being clean [with] W/C (wound cleaner). Recommendations/New Interventions included; "...Clean [with] W/C, pat dry, apply thera-honey and cover [with] Optifoam every Mon, Wed & Friday & PRN; Resident placed on air mattress 9/9/14..."

Review of a Weekly Pressure Ulcer QA&A Log dated for the week of 9/28/14 revealed the resident had a Stage II pressure ulcer to the left buttock measuring 1.2 x 2.0 x 0.2 with no odor but positive for drainage. There was also a Stage III pressure ulcer to the coccyx measuring 1.0 x 1.0 x 0.4 with no odor but positive for drainage.

Medical record review of a TAR dated 9/1-9/30/14 revealed the weekly skin assessments were not documented as completed on 9/6, 9/13 or 9/26/14.

Medical record review of a Weekly Pressure Ulcer Record dated 10/5/14 revealed Wound #1 to the "...coccyx closest to inside..." as an unstageable pressure ulcer measuring 1.7 x 1.5 x 1 cm. There was no exudate, the wound bed was black. Wound #2 was located on the "...(R) buttock outter area...", was a Stage II pressure ulcer measuring 1.9 x 2.6 x .2 with a scant amount of serous exudate. LPN #6 documented "...Sm. (small) amt. (amount) yellow slough [upper] (R) corner.."

Medical record review of a TAR dated 10/1-10/31/14 revealed the weekly skin

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F 314	Continued From page 25 assessments were not documented as completed on 10/6 or 10/13/15. A physician's order dated 10/5/14 to "...Cleanse inner area @ (at) coccyx [with] W/C, apply Santyl (medicine that removes dead tissue from wounds) to wound bed, pack [with] maxorb rope (alginate wound dressing that absorbs moderate to heavy drainage), cover [with] optifoam..." was not documented as completed on 10/16/14. Continuation of the order to "...Cleanse (R) buttock outer area [with] W/C apply hydrogel (helps create and maintain a moist environment) and cover daily and PRN..." was not documented as completed on 10/16 and 10/18/14. Medical record review of a physicians order dated 10/20/14 revealed "...Send to...ER (Emergency Room) for evaluation of buttock wound-eschar/slough-foul, drainage-undermining...evaluation for debridement potential..." Interview with the DON on 3/18/15 at 4:00 PM in the DON's office confirmed the staff nurses had been responsible for assessing and documenting weekly skin assessments on their assigned residents, and documenting the Weekly Pressure Ulcer Record when a resident was known to have a pressure ulcer. The DON stated, "The nurses don't know how to stage a wound...we need a consistent treatment nurse." Interview with the DON on 3/30/15 at 4:00 PM in the conference room confirmed the weekly Head to Toe Skin Checks should be completed on all residents. Continued interview confirmed the	F 314		

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F 314	Continued From page 26 assessments were not completed as ordered. Interview with LPN #1 on 3/31/15 at 1:10 PM in the conference room confirmed the Head to Toe Skin Check sheet was to be completed upon admission and weekly thereafter on all residents whether they had a wound or not. Continued interview confirmed the weekly Head to Toe Skin Check was also to be documented on the MAR on a weekly basis for those residents that had wounds, or as ordered by the physician. Interview with RN #1 on 3/31/15 at 1:50 PM in the conference room confirmed Resident #2 was bed and chair bound and was dependent on staff for her care and mobility. The RN confirmed seeing the resident frequently laying in a geri-chair in a reclined position slumped to one side or the other. Interview with the DON on 3/31/15 at 6:30 PM in the conference room confirmed Resident #2 did not receive weekly Head to Toe Skin assessments as ordered. The DON confirmed there was no documentation on 8/4, 8/11, 8/18, 9/8, 9/15, 9/22 or 9/29/14 the resident received a Head to Toe Skin check. Continued interview with the DON confirmed the resident had a documented injury of a self-inflicted abrasion to her left medial buttock measuring 1 x 0.2 cm due to "...long hard nails...scratches often..." The DON confirmed the Past Interventions Attempted documented "N/A" was not correct, as the injury on 7/8/14	F 314		

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F 314	Continued From page 27 interventions included to trim the residents nails. The DON confirmed there was no documentation the residents nails had been trimmed after the injury on 7/8/14 or the injury on 8/8/14. Continued interview confirmed the resident was to receive wound care to the left medial buttock every 3 days and PRN and there was no documentation the resident received wound care on 8/14, 8/17, 8/20, or 8/29/14. The DON confirmed the wound to the left buttock had increased to 2.2 x 3.6 cm as documented on 9/8/14 and was now a Stage II pressure ulcer. The DON confirmed by 9/28/14 the resident was documented to have 2 pressure ulcers; the Stage II to the left buttock and a Stage III to the coccyx measuring 1.0 x 1.0 x 0.4; by 10/5/14 the Stage II pressure ulcer to the buttock measured 1.9 x 2.6 x 0.2 cm and the coccyx pressure ulcer measured 3.5 x 3.0 x 3cm, was unstageable, and the wound bed was black. The DON confirmed new treatment orders to both of these wounds was ordered on 10/5/14, and there was no documentation the resident received pressure ulcer treatment to the coccyx on 10/16/14 and no pressure ulcer treatment was received to the buttock on 10/16 or 10/18/14. Continued interview with the DON confirmed the resident was transferred to "...ER (Emergency Room) for evaluation of buttock wound-eschar/slough-foul odor, drainage-undermining...evaluation for debridement potential..." on 10/20/14. Continued interview with the DON confirmed as a result of the facility's failure to trim the residents nails, missed skin assessments, and pressure ulcer treatment not completed as ordered,	F 314		

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F 314	Continued From page 28 Resident #2 suffered actual harm as the facility failed to prevent and treat a scratch to the buttock measuring 1 x 0.2 cm on 8/8/14 which developed into a Stage II pressure ulcer by 10/5/14 measuring 1.9 x 2.6 x 0.2 cm; a second pressure ulcer to the coccyx developed on 9/28/14 as a Stage III and increased to an unstageable pressure ulcer with eschar, foul odor, drainage and undermining measuring 1.7 x 1.5 x 1 cm by 10/5/14 and increasing to 3.5 x 3.0 x 3.0 cm by 10/18/14. The resident had to be sent to the ER on 10/20/14 for evaluation and treatment of the pressures ulcers as the facility failed to prevent and provide the necessary treatment for the resident which resulted in actual harm to t Resident #2. Medical record review of Resident #5 revealed the resident was readmitted to the facility on 2/19/15 with diagnoses including Aftercare for Healing Traumatic Fracture of Hip, Diabetes Mellitus, Congestive Heart Failure, Atrial Fibrillation (abnormal heart rhythm), Muscle Weakness and Difficulty in Walking. Medical record review of a Care Plan initiated 12/2/14 and revised on 3/5/15 revealed "...has potential/actual skin issues... Provide wound care/preventative skin care per order (initiated 12/2/14)...Treatment as ordered (initiated 3/5/15)..." Medical record review of Nursing Admission Data Collection dated 2/19/15 revealed " ...Skin Assessment: Coccyx, Skin Shearing, 7 x 2 cm; Right Trochanter (hip), Surgical Incision, 30 x 1 cm...Left Heel, Pressure, 3 x 2 cm,	F 314		

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F 314	Continued From page 29 Unstageable... " Medical record review of Wound Care Specialist Initial Evaluation dated 2/27/15 revealed "...Stage III Pressure Wound on the Left, Medial Buttock..." Medical record review of the physician's orders revealed no orders for wound care to the coccyx/left medial buttock/sacrum area from 2/19/15 until 2/27/15 when the resident was seen by the Wound Care Specialist. Medical record review of a physician's order dated 2/27/15 revealed "...Sacrum... Cleanse with wound cleaner, pat dry, apply SurePrep (skin protectant) to wound borders, apply Santyl (topical ointment aids in wound healing) to wound bed only and cover with dry dressing QOD (every other day) and PRN..." Medical record review of the 2/2015 and 3/2015 TAR revealed pressure ulcer treatment to the left sacrum was not documented on 2/28, 3/1, 3/2, 3/3 and 3/11/15. Medical record review of the Skin-Head to Toe Skin Checks dated 2/26/15 revealed "... Sacrum, Pressure, 3.5cm x 4.5cm, depth 0.3cm, Stage III..." Medical record review of the Nursing Initial Plan of Care with an admission date of 2/19/15 revealed "...has potential/actual skin issues...Interventions: Treatments as ordered..." Interview with LPN # 3 on 3/30/15 at 11:15 AM in the conference room, when asked why the LPN did not call the physician on 2/19/15 to obtain orders for wound treatment, the LPN stated, "I	F 314		

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F 314	Continued From page 30 didn't know I was supposed to get orders and put them in the computer." Interview with LPN # 1 on 3/31/15 at 1:10 PM in the Conference Room revealed "The initial assessment is completed within the first couple of hours. The Assistant Director of Nursing (ADON) puts in the orders and we double check them. The Nurses are responsible for checking the orders. We call the hospital, if needed, for other orders or call the doctor." Interview with the DON on 3/31/15 at 6:00 PM in the Conference Room confirmed that Resident #5 had no pressure ulcer treatment orders from date of admission 2/19/15 until 2/27/15 when seen by the wound care specialist and then was assessed to have a Stage III pressure ulcer to the left medial buttock. Continued interview confirmed by not obtaining and implementing physician orders for pressure ulcer prevention and treatment, the facility failed to prevent a Stage III pressure ulcer which resulted in actual harm to Resident #5. Medical record review revealed Resident #1 was admitted to the facility on 2/27/15, discharged to the hospital on 3/1/15, re-admitted on 3/5/15 and discharged back to the hospital on 3/16/15 with diagnoses including Pneumonia, Congestive Heart Failure, Hypertension, and Flaccid Hemiplegia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/15 documented the resident required extensive assistance from 2 people for bed mobility and	F 314		

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F 314	Continued From page 31 transfers, assistance from 1 person for dressing, eating, toileting, and personal hygiene, and was totally dependent for bathing. Medical record review of the Nursing Initial Plan of Care, effective date 2/27/15 and signed on 3/11/15 revealed, "...Potential/Actual Skin Issues related to: Pressure Ulcer related to Incontinence, pressure ulcer to sacrum with treatment in place..." Interventions include "...provide wound care/preventative skin care per order; Skin checks weekly per facility protocol, document findings; Notify MD of changes in wound or emerging wounds; Turn and reposition frequently to decrease pressure...try/dry and provide pericare q2h (every 2 hours) and prn for incontinence..." Medical record review of a Weekly Pressure Ulcer Record dated 2/28/15 completed by LPN #3 revealed the existence of a pressure ulcer to the left gluteal fold measuring 7 x .5 cm and described as "...blood filled blister to left gluteal fold. Unopen..." Medical record review of a Nursing Admission Data Collection assessment with an effective date of 3/5/15 completed by LPN #2 revealed the presence of moisture on a coccyx wound measuring 7 x 10.2 cm. Continued review revealed "...coccyx irregular shape (butterfly shape) thin layer of skin peeling, area red, small area yellow slough at 9 o'clock..." Review of the Wound Care Specialist Initial Evaluation notes dated 3/5/15 revealed an unstageable (due to necrosis) pressure ulcer of the sacrum measuring 6 x 8 x 0.3 cm. The wound was 30% yellow necrotic tissue, 20% granulation	F 314		

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F 314	Continued From page 32	F 314		

tissue and 50% skin. The assessment and plan included "...Santyl (wound medication)-Every Two Days and PRN, Hydrocolloid (dressing)-Every Two Days and PRN with follow-up within 7 days. The facility could not produce any additional follow-up notes from the Wound Care Specialist after 3/5/15.

Medical record review of the TAR dated 3/1/15-3/31/15 revealed a verbal order for "...Santyl Ointment 250 UNIT/GM (gram) (Collagenase) Apply to Sacral Wound topically every day shift every other day for Sacral wound Cleanse with WC (wound cleaner), pat dry, cover wound boarder with Sureprep (wound treatment), apply Santyl (wound bed only), cover with Hydrocolloid dressing, and change QOD (every other day) and PRN for soiling..." The order date was 3/6/15. Continued review revealed no documentation for wound care/treatment was noted on 3/7, 3/9, or 3/11/15.

Interview with the DON on 3/31/15 at 5:20 PM in the conference room confirmed Resident #1 had a physician's order for pressure ulcer treatment dated 3/6/15 and no pressure ulcer treatment was documented until 3/13/15. The DON also acknowledged the inconsistencies in the assessments of the resident's wound regarding location i.e., left gluteal fold versus coccyx versus sacrum; the measurements of the wound upon admission i.e., 7 x 10.2 versus 6 x 8 x 0.3; the difference in descriptions i.e., butterfly shape, red, peeling skin versus unstageable due to necrosis.

Medical record review of Resident #6 revealed the resident was admitted to the facility on 3/12/15 with diagnoses including Recent Right Hip Fracture, Cerebrovascular Accident,

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F 314	Continued From page 33 Pneumonia and Deep Vein Thrombosis. Medical record review of Nursing Admission Data Collection dated 3/12/15 revealed "... Skin Assessment ...Right Buttock, Abrasion; Left Buttock, Abrasion; Right Thigh (rear), Surgical Incision; Right Ankle (outer), Bruising, 3.0 x 1.5 [cm]; Right Heel, Pressure, 3.5 x 4.8 [cm], Unstageable; Left Heel, Pressure, 1.5 x 2.5 [cm], Unstageable..." Medical record review of MDS dated 3/19/15 revealed the resident requires extensive assistance of 2 or more people for turning and positioning. Further review of the MDS revealed the resident had 1 Stage II Pressure Ulcer, 1 Stage III Pressure Ulcer and 2 unstageable Pressure Ulcers upon admission to the facility. Medical record review of the TAR dated 3/2015 revealed "...Right and Left Heel ...Sureprep QD and PRN ...Right Buttock ...Cleanse with WC, pat dry, apply Alginate Cover with Dry Dressing and change QD..." Medical record review of Head to Toe Skin Checks dated 3/19/15 revealed "...Right Buttock, Pressure, 0.5 x 0.5 [cm]...Right Heel , Pressure, 1.7 x 3.0 [cm], Unstageable, Left Heel, Pressure, 1.6 x 2.7 [cm], Unstageable..." Medical record review of Skin-Head to Toe Skin Checks dated 3/26/15 revealed "..Right Buttock, Pressure, 0x 0 [cm], depth 0 [cm]...Right Heel , Pressure, 3.0 x 4.0 [cm], Unstageable, Left Heel, Pressure, 1.6 x 2.7 [cm], Unstageable..." Medical record review of Nursing Initial Plan of Care dated 3/12/15 revealed "...has	F 314		

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F 314	Continued From page 34 potential/actual skin issues...Interventions: ...Skin checks weekly per facility protocol ...Turn and reposition frequently to decrease pressure...." Medical record review of Care Plan dated 3/27/15 revealed "...admitted with several pressure ulcers ...Stage III Right Buttock and unstageable to Bilateral (both) Heels... Administer treatment as ordered and observe for effectiveness..." Medical record review of TAR dated 3/1/15-3/31/15 revealed pressure uilcer treatment to the right and left heels was not documented on 3/17/15 and 3/19/15. Medical record review of TAR dated 3/1/15-3/31/15 revealed pressure uilcer treatment to the right buttock was not documentedon 3/17/15 and 3/19/15. Interview with the DON on 03/18/15 at 11:40 AM in the DON's office, when asked about missing documentation on the TARS, the DON stated, "Blanks on the MAR or TAR were missed or not done." Interview with the DON on 3/19/15 at 3:00 PM in the DON's office, when asked about presure ulcer and infection control competency evaluations for nurses, the DON stated, "We have none. We expect nurses to use their basic nursing knowledge."	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	**F441. Infection Control** 1. Skin audit conducted on affected Resident by treatment nurse and no negative outcomes were observed due to alleged deficient practice. Conducted a one-on-one in-service with Nurse#2	

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F 441	Continued From page 35 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain	F 441	regarding alleged deficient practice, and following Physician orders/protocols for skin treatments and wound care. 2. Residents currently residing in facility with skin issues have the potential to be affected by alleged deficient practice. Skin audits on current residents were conducted by DON/Unit manager/ADON/charge nurses. No other Residents found to be affected by deficient practice. 3. DON/ADON/Designee will conduct visual audits on 2 treatments a week for 4 weeks, 2 treatments monthly x 2 months. to validate skin treatments are performed as ordered by the Physician and per Facility protocol. Education to Licensed Nurses related to wound staging, measuring of wounds, performing treatments using infection control standards, and documentation conducted by Michael Britton, Certified Wound Nurse and Dr. Powell, Wound Care Physician. 4. Any issues identified by the treatment audits will be immediately addressed and corrective measures taken for the Resident(s) affected. Results will be further discussed by the QAPI team, monthly x3, consisting of Administrator, DON, ADON, Unit Manager, Social Services Director, Medical Director, Dietary Manager, Maintenance Manager, Activities Director, and Medical Director.	05/10/2015

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F 441	Continued From page 36 infection control practices during wound care for 1 (Resident #3) resident of 7 residents reviewed for pressure ulcers. The findings included: Medical record review of Resident #3 revealed the resident was readmitted to the facility on 03/03/15 with diagnoses including Clostridium Difficle, Chronic Kidney Disease, Generalized Pain, Muscle Weakness, Anemia and Diabetes Mellitus. Medical record review of Physicians Orders dated 03/09/15 revealed "...Right outer thigh (donor site) and outer calf, Cleanse with warm water and soap, pat dry and cover with Optifoam (an absorbant dressing) QOD (every other day) and PRN (as needed)for soiling... Cover all scabbed areas (Healing Deep Tissue Injuries) on heel and toes with Sureprep (a skin protectant) BID (twice daily)..." Observation of wound care on 3/19/15 at 1:40 PM in Resident # 3's room revealed Licensed Practical Nurse (LPN) # 2 donned the isolation gown and mask and gathered the wound care supplies. The nurse then knocked and entered the resident's room, explained the wound care procedure to the resident, washed the hands and donned clean gloves. Continued observation revealed the LPN then moved the resident's personal belongings from the bedside table and proceeded to complete a head to toe assessment including touching the resident's ears, underarms, peri-area, and separated the buttocks to visualize a healing coccyx pressure ulcer. The LPN placed the wound care supplies on paper towels on the bedside table then opened and dated the	F 441		

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F 441	Continued From page 37 Optifoam dressing. The LPN removed the soiled right posterior thigh Optifoam dressing and placed it in the trash can. The LPN cleaned the right thigh with water and patted the area dry. Without changing the soiled gloves, the LPN then removed the dressing from the right calf, proceeded to touch and squeeze the wound, and drainage was noted. The LPN removed the soiled gloves, placed the dressing in the trash can, washed the hands and donned clean gloves. The Certified Nurse Assistant (CNA) allowed the resident's uncovered, right calf wound to touch the soiled bed linens. The LPN applied SurePrep to the right ankle and toe. Continued observation revealed LPN # 2 removed the isolation gown, mask and gloves and disposed of them in the red trash can, used hand sanitizer on the hands and left the resident's room. Interview with the DON on 3/19/15 at 3:00 PM in the DON's office, when asked about presure ulcer and infection control competency evaluations for nurses, the DON stated, "We have none. We expect nurses to use their basic nursing knowledge." Continued interview with the DON, when asked "do you have a policy for doing dressing changes?", the DON stated, "just the skin management". The DON was also asked if the facility has a policy or procedure for treating wounds. The DON confirmed the facility has no policy or procedure on wound treatment.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514	**F514. Clinical Records** 1. R # 3 had skin audit and documentation to reflect current skin concern on 4/22/15. Residents# 1,2,5,6, no longer reside in facility.	

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F 514	Continued From page 38 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the weekly pressure ulcer log, and interview the facility failed to maintain accurate, complete clinical records for 5 (Resident #1, Resident #2, Resident #3, Resident #5 and Resident #6) of 7 residents reviewed. The findings included: Medical record review revealed Resident #1 was admitted to the facility on 2/27/15, discharged to the hospital on 3/1/15, re-admitted on 3/5/15 and discharged back to the hospital on 3/16/15 with diagnoses including Pneumonia, Congestive Heart Failure, Hypertension, and Flaccid Hemiplegia. Review of the facility policy Physician Orders with a revision date of 9/11 revealed "...Physician orders are obtained to provide clear direction regarding the care of the resident...Discipline-specific treatment orders can be written by a licensed health care professional, but must be counter-initialed and dated by a licensed nurse acknowledging receipt and notification of the physician..."	F 514	2. Residents who have skin concerns have the potential to be affected by this alleged deficiency. Initial audit of TARS conducted by DON/ADON/Unit Manager/treatment nurse for documentation and assessments completion/accuracy. Corrective actions taken for Residents identified with missing documentation/assessments regarding skin and skin concerns. 3. Skin audits will be scheduled Sunday through Thursday and will be reviewed in Morning meeting Monday through Friday. Any not completed will be done immediately and education provided to Licensed nurses. Treatment nurse is currently in place to oversee treatment implementation and documentation. Second Documentation review, Monday through Friday, conducted by Don/Unit manager /ADON/MDS nurse. Education to Licensed Nurses related to wound staging, measuring of wounds, performing treatments using infection control standards, and documentation conducted by Michael Britton Certified Wound Nurse and Dr. Powell Wound Care Physician with post-test competency. 4. Audits of TARS of residents with wounds will be conducted 3 times weekly x 4 weeks, 2 times a week x 4 weeks, and 1 x week x 4 weeks. Concerns will be reported to monthly x 3 to the QAPI committee consisting of Administrator, DON, ADON, Unit Manager, Social Services Director, Medical Director, Dietary Manager, Maintenance Manager, Activities Director, and Medical Director.	05/10/2015

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F 514	Continued From page 39 Medical record review of the Treatment Administration Record (TAR) dated 3/1/15-3/31/15 revealed a verbal order dated 3/6/15 for "...Santyl (wound medication) Ointment 250 UNIT/GM (gram) (Collagenase) Apply to Sacral Wound topically every day shift every other day for Sacral wound Cleanse with WC (wound cleaner), pat dry, cover wound boarder with Sureprep (wound treatment), apply Santyl (wound bed only), cover with Hydrocolloid dressing, and change QOD (every other day) and PRN (as needed) for soiling..." Continued review revealed no documentation for wound care/ pressure ulcer treatment was noted on 3/7, 3/9, or 3/11/15. The notation for 3/9/15 revealed "...3=Hold due to Condition..." No documentation as to what the "condition" was which warranted holding the wound treatment could be found. Medical record review of the Nursing Daily Skilled Charting dated 3/7, 3/10, and 3/16/15 revealed no documentation regarding skin changes to the resident and a "No" was marked for any changes in the resident's Skin Integrity. There were no Nursing Daily Skilled Charting notes for 3/6, 3/8, 3/9, 3/11, 3/12, 3/13, 3/14 and 3/15/15 for the resident. Review of the Weekly Pressure Ulcer QA & A Log for the week of 3/5/15 revealed the resident had an unstageable pressure ulcer of the sacrum measuring 6 x 8 x 0.3 cm and was being treated with Santyl and a hydrocolloid dressing. The week of 3/13/15 documented the resident had an unstageable cluster pressure ulcer to the sacrum measuring 6 x 7.5 x 0.3 and was being treated with Santyl and a hydrocolloid dressing QOD. The log contained no initials or signature of the person	F 514		

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F 514	Continued From page 40 documenting the wound site, staging, size and treatment. Interview with LPN #3 on 3/30/14 at 2:55 PM in the conference room confirmed the process for obtaining and transcribing orders from the Wound Care Specialist as follows: This nurse rounds with the physician once a week on Thursdays to each resident noted to have a wound. The physician describes, measures, stages and treats the wound, and gives a verbal order and the nurse records it on her own piece of paper. She then reviews it with the physician after rounds are completed and re-writes it onto the Weekly Pressure Ulcer QA & A Log or the Weekly Non-Pressure Ulcer QA & A Log. From there she enters each treatment order into the computer, prints a copy to be faxed to the pharmacy and another copy for the physician to sign the next week when he rounds again. The LPN confirmed there was no hand written verbal order to read back, note off, or have checked by another nurse and kept as permanent documentation in the resident's medical record. Interview with the DON on 3/31/15 at 5:20 PM in the conference room confirmed Resident #1 had a physician's order for pressure ulcer treatment dated 3/6/15 and no treatment was documented until 3/13/15. The DON also acknowledged the inconsistencies in the documentation of the resident's pressure ulcer regarding location i.e., left gluteal fold versus coccyx versus sacrum; the measurements of the wound upon admission i.e., 7 x 10.2cm versus 6 x 8 x 0.3 cm ; the difference in descriptions i.e., butterfly shape, red, peeling skin versus unstageable due to necrosis. Further interview with the DON confirmed the absence of the Nursing Daily Skilled Charting notes for 8 of	F 514		

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the 12 days the resident was in the facility, as well as the incomplete charting under the skin section of the daily assessment on 3/7, 3/10, and 3/16/15. Further interview confirmed the same process that LPN #3 described in obtaining and transcribing treatment orders from the Wound Care Specialist. The DON stated, "You don't have to write down a verbal order anymore, you can just type it right into the computer."

Medical record review revealed Resident #2 was admitted on 10/4/11, readmitted on 5/7/12, and discharged on 10/20/14. Continued medical record review revealed diagnoses including Anemia, Hyperlipidemia, Depression, Hypothyroidism, Pneumonia, Urinary Tract Infection, Arthritis and Coronary Artery Disease.

Medical record review of the resident's care plan for pressure ulcers dated 4/17/14 and updated 7/17/14, 10/6/14 and 10/18/14 revealed an approach to "complete a full body check weekly and document."

Continued medical record review of the weekly Head to Toe Skin Checks revealed that on the following weeks for 1/2014 through 10/2014 Head to Toe Skin Checks were not completed: 2/5/14, 2/19/14, 2/26/14, 3/5/14, 3/12/14, 5/28/14, 7/14/14, 8/4/14, 8/11/14, 8/18/14, 9/8/14, 9/15/14, 9/22/14, 10/13/14, and 10/20/14.

Medical record review of a Head to Toe Skin Check dated 7/28/14 revealed documentation of an abrasion to the left buttock.

Review of a facility Incident/Accident Report dated 8/8/14 revealed an injury of "...open area on her left medial buttock/self inflicted abrasion..."

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F 514	Continued From page 42 Review of a facility Incident/Accident Report dated 9/8/14 revealed "...wound on left buttock has increased in size - worse in last few days." Review of the Weekly Pressure Ulcer QA&A dated 9/21/14 revealed Resident #2 had a Stage III pressure ulcer to the coccyx measuring 1.4 x 1 x 0.4 cm and a Stage II pressure ulcer to the left buttock measuring 2.4 x 1.6 x 0.2 cm. Review of the Weekly Pressure Ulcer QA&A dated 9/28/14 revealed Resident #2 had a Stage III pressure ulcerto the coccyx measuring 1.0 x 1.0 x 0.4 cm and a Stage II pressure ulcer to the left buttock measuring 1.2 x 2.0 x 0.2 cm. Review of the Weekly Pressure Ulcer QA&A dated 10/6/14 revealed Resident #2 had a Stage III pressure ulcerto the coccyx measuring 1.0 x 1.0 x 0.4 cm and a Stage II pressure ulcer to the left buttock measuring 2.8 x 2.0 x 0.2 cm. Medical record review of the Weekly Pressure Ulcer Record dated 9/26/14 revealed documentation of a pressure ulcer to the right buttock ("closest to outside")measuring 2.4 x 1.6 x 0.2 cm (no stage documented) and a Stage III pressure ulcer to the right buttock (closest to inside) measuring 1.4 x 1.0 x 0.4 cm. Medical record review of the Weekly Pressure Ulcer Record dated 10/5/14 revealed documentation of a pressure ulcer to the "coccyx (closest to inside)" measuring 1.7 x 1.5 x1 cm, "coccyx wound bed black in color" and a Stage II pressure ulcer to the right buttock measuring 1.9 x 2.6 x 0.2 cm.	F 514		

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F 514	Continued From page 43 Interview with the Director of Nursing (DON) on 3/29/15 at 10:15 AM in the DON's office, the DON confirmed the Weekly Pressure Ulcer Record description of the resident's wounds and the description of the wounds on the resident's care plan were inconsistent. Medical record review of the Weekly Head to Toe Skin checks revealed no skin checks were completed on Resident #2 after 8/2014. Continued review revealed no Weekly Pressure Ulcer Record documentation for pressure ulcers for the weeks of 8/18, 8/22, 8/29, 9/5, 9/12, 9/19, and 10/13/14 after the resident was identified to have a pressure ulcer on 8/8/14. Review of the Weekly Pressure Ulcer QA&A reports revealed weekly reports were not completed for Resident #2 after 10/6/14. Medical record review of the resident's care plan for pressure ulcers revealed an update on 8/8/14 to reflect a "...Stage II left medial buttock..."; update on 9/8/14 to reflect a "...Stage II buttock..."; update on 10/5/14 to reflect "...unstageable right buttock with eschar..."; update on 10/18/14 to reflect "...right buttock with eschar - slough depth, undermining, foul odor 3.5 x 3.0 x 3.0 cm..." Medical record review of the 8/2014 TAR revealed an order to "...apply Optifoam to left medial buttock every 3 days..." Continued review of the TAR revealed pressure ulcer treatments were not documented on the following dates: 8/14, 8/17, 8/20, and 8/29/14. Medical record review of the 9/2014 TAR revealed an order to "...apply Optifoam to left	F 514		

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medial buttock every 3 days..." Continued review of the TAR revealed pressure ulcer treatments were not documented on the following dates: 9/10, 9/13, and 9/16/14.

Medical record review of physician's orders on 9/26/14 revealed an order to "...clean wound on buttock with wound cleaner, pat dry, apply Thera Honey and cover with Optifoam..." every 3 days. There was no documentation on the 9/2014 TAR of this pressure ulcer treatment being administered.

Medical record review of the 10/2014 TAR revealed a treatment to "...cleanse inner area at coccyx with wound cleaner, apply Santyl to wound bed and pack with Maxorb rope, cover with Optifoam..." Continued review of the TAR revealed pressure ulcer treatment was not documented on 10/16/14.

Review of the 10/2014 TAR revealed a treatment to "...cleanse outer area right buttock with wound cleaner, apply hydrogel and cover daily..." Continued review of the TAR revealed pressure ulcer treatments were not documented on 10/16 and 10/19/14.

Interview with the DON on 3/31/14 at 6:30 PM in the conference room confirmed wound treatments were not provided as ordered by the physician.

Medical record review of Resident #3 revealed the resident was readmitted to the facility on 3/3/15 with diagnoses including Clostridium Difficle, Chronic Kidney Disease, Generalized Pain, Muscle Weakness, Anemia and Diabetes

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F 514	Continued From page 45 Mellitus. Medical record review of a TAR entry dated 3/9/15 revealed "...Right outer thigh (donor site), outer calf, Cleanse with warm water and soap, pat dry and cover with Optifoam QOD (every other day)and PRN for soiling...Cover all scabbed areas (Healing Deep Tissue Injuries) on heel and toes with Sureprep (a skin protectant) BID (twice daily)..." Medical record review of a TAR dated 3/1/15-3/31/15 revealed "...Healing Deep Tissue Injury (DTI), cover scabbed areas on heel and toes with Sureprep BID. Continued review of the TAR dated revealed pressure ulcer treatment to the "heel and toes" was not documented on 3/6, 3/7 and 3/10/15. Interview with the DON on 3/18/15 at 11:40 AM in the DON's office confirmed blanks on the TAR were missing pressure ulcer treatment documentation. and the DON stated, "I looked for...documentation and was unable to find it...there is an issue with documentation." Medical record review of Resident #5 revealed the resident was readmitted to the facility on 2/19/15 with diagnoses including Aftercare for Healing Traumatic Fracture of Hip, Diabetes Mellitus, Congestive Heart Failure, Atrial Fibrillation (abnormal heart rhythm), Muscle Weakness and Difficulty in Walking. Medical record review of the Nursing Admission Data Collection dated 2/19/15 revealed "...Skin Assessment: Coccyx, Skin Shearing, 7 x 2 [cm]; Right Trochanter (hip), Surgical Incision, 30 x 1 [cm] ...Left Heel, Pressure, 3 x 2 [cm],	F 514		

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F 514	Continued From page 46 Unstageable..." Medical record review of a physician's order dated 2/27/15 revealed "...Left heel... Cleanse with wound cleaner, pat dry, apply SurePrep (skin protectant) to wound borders, apply Santyl (topical ointment aids in wound healing) to wound bed only and cover with dry dressing QOD (every other day) and PRN..." Review of a physician's order dated 2/27/15 revealed "...Sacrum...Cleanse with wound cleaner, pat dry, apply SurePrep to wound borders, apply Santyl to wound bed only and cover with dry dressing QOD and PRN..." Medical record review of a physician's order dated 3/3/15/15 revealed "...Right Hip ...Cleanse with wound cleaner, pat dry, coat staple line with sure prep and cover with long boarder gauze QD (every day) and PRN for soiling ..." Review of a physician's order dated 3/3/15 revealed "...Left Heel ...Cleanse with wound cleaner, pat dry, apply sure prep to wound borders, apply Santyl to wound bed only, apply Alginate (an absorbent wound dressing), and cover with dry dressing (not foam) QOD and PRN for soiling..." Medical record review of a TAR dated 2/1/15-2/28/15 revealed pressure ulcer treatment to the left heel was not documented on 2/28/15. Review of a TAR dated 2/1/15-2/28/15 revealed pressure ulcer treatment to the left sacrum was not documented on 2/28/15. Medical record review of a TAR dated	F 514	**Disclaimer** Submission of this response and plan of correction is not a legal admission that deficiency exists or that this statement of deficiencies was correctly cited, and is also not to be construed as an admission of interest against the facility, the Executive Director, or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) ten days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. This plan of correction is submitted by the facility's credible allegation of compliance.	

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F 514	Continued From page 47 3/1/15-3/31/15 revealed pressure ulcer treatment to the left heel was not documented on 3/10/15 and 3/21/15. Review of a TAR dated 3/1/15-3/31/15 revealed pressure ulcer treatment to the left sacrum was not documented on 3/1, 3/2, 3/3, 3/4 and 3/11/15. Review of TAR dated 3/1/15-3/31/15 revealed pressure ulcer treatment to the right hip was not documented on 3/7/15, 3/10/15, 3/11/15, 3/13/15 and 3/18/15. Interview with the DON on 3/18/15 at 11:40 AM in the DON's office confirmed blanks on the TAR were missing pressure ulcer treatment documentation and the DON stated, "I looked for...documentation and was unable to find it...there is an issue with documentation." Medical record review of Resident #6 revealed the resident was admitted to the facility on 3/12/15 with diagnoses including Recent Right Hip Fracture, Cerebrovascular Accident, Pneumonia and Deep Vein Thrombosis. Medical record review of the Nursing Admission Data Collection dated 3/12/15 revealed "...Skin Assessment...Right Buttock, Abrasion; Left Buttock, Abrasion; Right Thigh (rear), Surgical Incision; Right Ankle (outer), Bruising, 3.0 x 1.5 cm; Right Heel, Pressure, 3.5 x 4.8 cm, Unstageable, Left Heel, Pressure, 1.5 x 2.5 cm, Unstageable..." Medical record review of a physician's order dated 3/12/15 revealed "...Right Thigh...apply Sureprep QD and PRN..."	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 48 Review of a physician's order dated 3/12/15 revealed "...Left Buttock ...Every day and night shift...Apply Barrier Cream BID..." Medical record review of a physician's order dated 3/17/15 revealed "...Right Buttock ...Cleanse with WC (Wound Cleaner), pat dry, apply Alginate, Cover with Dry Dressing and change QD..." Medical record review of Physician's Orders dated 3/27/15 revealed "...Right Lateral Ankle ... Cleanse with WC, pat dry, apply Alginate, Cover with Dry Dressing and change QD and PRN for soiling..." Medical record review of a TAR dated 3/1/15-3/31/15 revealed pressure ulcer treatment to the right lateral ankle was not documented on 3/28/15. Medical record review of TAR dated 3/1/15-3/31/15 revealed pressure ulcer treatment to the right and left heels was not documented on 3/17/15 and 3/19/15. Medical record review of a TAR dated 3/1/15-3/31/15 revealed pressure ulcer treatment to the right buttock was not documented on 3/17/15 and 3/19/15. Medical record review of a TAR dated 3/1/15-3/31/15 revealed pressure ulcer treatment to the right thigh was not documented on 3/19/15. Medical record review of a TAR dated 3/1/15-3/31/15 revealed pressure ulcer treatment to the left buttock was not documented on 3/16 at 11:00PM, 3/19 at 7:00AM and 3/19/15 at	F 514		

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F 514	Continued From page 49 11:00PM. Medical record review of Head to Toe Skin Checks dated 3/19/15 revealed "...Right Buttock, Pressure, 0.5 x 0.5 cm...Right Heel, Pressure, 1.7 x 3.0 cm, Unstageable; Left Heel, Pressure, 1.6 x 2.7 cm, Unstageable...." Interview with the DON on 3/18/15 at 11:40 AM in the DON's office confirmed blanks on the TAR were missing pressure ulcer treatment documentation and the DON stated, "I looked for ... documentation and was unable to find it... there is an issue with documentation."	F 514		